ARTICLE I

ARIZONA LOCAL GOVERNMENT
SCHEDULE OF BENEFITS

		In-Network	Out-of-Network
1.01	***BASIC BENEFITS*** (No Deductible)	100%	100%
	Second Opinions when required by AHG		
	Routine Wellness Benefits: *($500 per Calendar Year)*		
	Routine Physicals		
	Well Baby Care *(age 25 months and older)*		
	AZ School Required Immunizations *(ages 4-15)*		
	Diabetic Nutritional Counseling *($200 per Calendar Year)*		

1.02 ***MAJOR MEDICAL BENEFITS*** (Subject to Deductible with the exception of co-pay services)

Deductibles:		In-Network	Out-of-Network
Individual Deductible per Calendar Year	**2010**	$250	$750
	2011	$300	$750
Family Deductible per Calendar Year	**2010**	$750	$2,250
	2011	No Family Deductible / Individual Deductible applies	

Covered Percentages:		
Physician Office Services *(exams, x-rays, lab, surgery)*		
- Primary Care Physician	$25 *co-pay*	50%
- Specialist	$35 *co-pay*	50%
Well Baby Exams and Immunizations *(ages 0-24 months)*	$25 *co-pay*	$25 *co-pay*
Chiropractic Care: $40 eligible per visit	$25 *co-pay*	50%
Laboratory		
Non-Complex (under $500)		
Independent Facility	$25 *co-pay*	50%
Hospital or Hospital Owned Facility	80%	50%
Complex (over $500)	80%	50%
X-rays/Radiology	80%	50%
Outpatient Hospital Services	80%	50%
Hospital Emergency Room *(co-pay waived if admitted)*	$100 *co-pay – 80%*	$100 *co-pay – 50%*
Inpatient Hospital	80%	50%
Preventive Colonoscopies	80%	0%
Ambulance Services	80%	Payable as In-Network
Durable Medical Equipment	80%	50%
All other eligible Major Medical Expenses	80%	50%

Annual Out-of-Pocket Maximums:		$1,500	NONE
	Effective 1/1/2011	$2,000	NONE

(Deductibles, Co-pays and Mental Health Care are not included. In-Network and Out-of-Network amounts do not cross accumulate.)

Outpatient Mental Health Care: *(26 visits per Calendar Year)*		80%	50%
Psychological Testing:		50%	50%
Inpatient Mental Health:	*(15 days per Calendar Year)*	80%	50%
	(Maximum of 30 days per lifetime)		

1.03 ***PLAN MAXIMUMS***

Durable Medical Equipment	$1,000 per item
Chiropractic Care	26 visits per Calendar Year
Outpatient Physical Therapy / Rehabilitation	$1,500 per condition
Home Health Care	60 visits per Calendar Year
Hospice Care	100 days
Skilled Nursing Facility	60 days per Calendar Year

1.04 ***HEARING AID BENEFIT*** *(Subject to Medical Deductible)*

Hearing Examination/Testing	$25 co-pay
Hearing Aid *(one every three years)*	50% *(subject to medical deductible)*
Maximum Payable:	$1,000

1.05 **PRESCRIPTION DRUG CARD**

Retail Pharmacy (up to a 30-day supply)	
Tier 1	$10.00 co-pay
Tier 2	$35.00 co-pay
Tier 3	$75.00 co-pay
Retail Pharmacy (up to a 90-day supply)	
Tier 1	$25.00 co-pay
Tier 2	$87.50 co-pay
Tier 3	$187.50 co-pay
Mail Order Pharmacy (up to a 90-day supply)	
Tier 1	$10.00 co-pay
Tier 2	$70.00 co-pay
Tier 3	$150.00 co-pay
Mandatory Specialty Medications (up to 30 day supply)	$75.00 co-pay

Below are descriptions of the Navitus Select Formulary drug tiers:

Tier 1 – Formulary generics and certain low cost brand name drugs
Tier 2 – Formulary brand name drugs and certain higher cost generic drugs
Tier 3 – Non-formulary drugs, both brand and generic
Mandatory Specialty Medications – Mandatory Specialty Medications are only available through the Navitus SpecialtyRx Program Pharmacy.

1.06 ***LIFETIME MEDICAL/Rx PLAN MAXIMUM*** *(Both In-Network and Out-of-Network combined)*

All Eligible Expenses $2,000,000

1.07 ***DENTAL BENEFITS***

Dental Deductible:

Individual Deductible per Calendar Year	**2010**	$50
	2011	$75
Family Deductible per Calendar Year	**2010**	$150
	2011	No Family / Individual Deductible applies

Percentages Payable:

Preventive Care	100%
Restorative Care	80%
Routine Extractions	80%
Endodontics	80%
Periodontics	80%
Oral Surgery	80%
Prosthodontic / Prosthetics	50%
Orthodontics (to age nineteen)	50%

Dental Benefit Maximums:

Maximum Benefit Payable per Calendar Year*	$1,750 *per person*
Lifetime Orthodontic Benefit	$1,750 *per person*

*Payments for Orthodontia are not included in the annual maximum

1.08 ***VISION BENEFITS***

Benefits Payable:

		Co-Pay	Benefits
Exams:	One (1) per Calendar Year	$10	$50
*Lenses:	One (1) set per Calendar Year	$10	$150
*Frames:	One (1) per Calendar Year	$10	$100
*Contacts:	Per Calendar Year	$0	$150

*Annually Plan covers Lenses & Frames <u>or</u> Contacts (not both)

1.09 *SHORT TERM DISABILITY BENEFIT*

Waiting Period:	45 Calendar days of Total Disability*
Benefits Payable:	
Percentage Payable	60% of Salary
Minimum Payable	$100 per week
Maximum Days Payable	135 calendar days
Survivor Benefit	30 calendar days
Pre-Existing Conditions:	Same exclusion as Medical Plan
Offsets:	Other Group STD Social Security Disability No Fault Auto Insurance Rehabilitation Income

*45 days and after all accrued paid leave has been exhausted

1.10 *LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT*

Benefits Available for Full-time employees only

Life Insurance Benefit	Per Schedule
Accidental Death & Dismemberment (AD&D)	Per Schedule

Coverage details, schedule reductions, and policy limitations are defined in your Life Insurance Certificate.

1.11 *HUMAN ORGAN TRANSPLANTS*

Coverage will be provided for eligible expenses incurred in conjunction with Medically Necessary, non-Experimental or Investigational Organ Transplants.

(A) *Special "Organ Transplant Network" Benefits*

Network Facilities:	Hospitals affiliated with the Plan's "Organ Transplant Network"
Transplant Services:	Heart, Lung, Heart/Lung, Kidney, Pancreas, Liver, Bone Marrow, Stem Cell (autologous, allogeneic)
Percentage Payable:	100% (Subject to the Lifetime Medical Plan Maximum)
Organ Procurement:	Covered (Charged to member's Medical Lifetime Maximum)
Deductible:	Waived for all transplant related services
*Travel Benefit:	$5,000 maximum when residing over 50 miles from the approved transplant facility. This allowance will be combined for the patient and one companion.

*Travel benefits are limited to commercial transportation to and from the site of the organ transplant center, reasonable and necessary lodging and meals.

The Plan is not responsible for any Covered Person's decision to receive treatment, services or supplies from an approved transplant facility, nor does the Plan make warrants or representations regarding the qualification of providers of treatment, services or supplies by a Network Facility.

All In-Network Organ Transplants must be coordinated through, and approved by, the Plan. To initiate these benefits and identify the Plan's "Organ Transplant Network" you must call AHG at (800) 847-7605. Failure to comply with Pre-Authorization will result in Out-of-Network benefits listed below.

(B) *Out-of-Network Benefits* (Subject to Plan Document language except as stated in 1.10 (A) above.)

Transplant Services:	Heart, Lung, Heart/Lung, Kidney, Pancreas, Liver, Bone Marrow/Peripheral Stem Cell (autologous, allogeneic)
Percentage Payable:	70%
Organ Procurement:	Not covered
Deductible:	$250 Major Medical
Maximum Benefit:	$100,000
Travel Benefit:	None